FY 2010-2011 Open Enrollment
Frequently Asked Questions

GENERAL QUESTIONS

1. I have not received my Open Enrollment material at home. What should I do?

The only Open Enrollment material being mailed to your home address is a Worksheet that will assist you when entering your benefit elections into the Benefit Enrollment System. Worksheets are being mailed Friday, April 16, 2010, to your home address on file in the PeopleSoft system. A copy of the Worksheet is also available on the Employee Benefits home page, under the Open Enrollment tab. It is not necessary for you to have your Worksheet in order to access the ADP portal and enroll in your benefits for the 2010/2011 Plan Year.

Open Enrollment materials, including the *What's New* Open Enrollment booklet, are only available online at the Employee Benefits Web site. The internal site is located on the Electronic Business Center (EBC) Intranet at ebc.maricopa.gov/ehi. The external site is located on the Internet at www.maricopa.gov/benefits.

2. I cannot remember my User ID and Password to access the ADP portal. What should I do?

Access the ADP portal at https://portal.adp.com and click on the '*Forgot my User ID'* or '*Forgot my Password*' links for assistance. Do not contact the Employee Benefits Division because due to privacy reasons, they do not have a record of your User ID or Password.

3. What happens if I do not make any elections during Open Enrollment?

If you do not make any elections, in most cases your coverage will default to the same benefits plans and the same level of coverage as you had in the 2009/2010 Plan Year. However, there are some exceptions. To receive discounts on your 2010/2011 monthly medical premiums, you must complete the Biometric Screening and Health Assessment by May 20, 2010. You will need to indicate that you completed those on the Benefit Enrollment System in order to receive your discount.

To participate in the Health Care FSA or the Dependent Care FSA, you will need to re-enroll for the 2010/2011 Plan Year. Your previous election will not carry over into the new Plan Year.

Employees enrolled in the HSA who wish to have employee contributions or a catch-up contribution into their HSA must indicate so via an Open Enrollment election.

Regarding the non-tobacco user incentive, review your previous response to ensure your response is still accurate.

If you waive medical coverage and wish to receive the medical waiver credit, you must submit proof of other coverage by June 1, 2010. Verification of other coverage should be submitted to the Employee Benefits Division on the Verification of Insurance Form for Medical Waiver Payment.

4. Can I add or drop dependents during Open Enrollment?

Yes, you may drop dependents during Open Enrollment or add those who meet all eligibility requirements. An independent auditing group retained by Maricopa County will contact you to request documentation as proof that your dependent is eligible for coverage. Failure to submit such documentation by the required deadline will result in your dependent being dropped from coverage.

5. What benefits changes are taking place for the new plan year?

Maricopa will continue offering the same medical plans administered by CIGNA. What is changing is that employee premiums have increased slightly. Deductibles have increased for some plans, and have changed from facility-based deductibles to annual deductibles for the Open Access Plus plans. Co-pays and out-of-pocket maximums have increased on most plans.

6. Why did copays, coinsurance, deductible, and out-of-pocket maximums increase for most plans?

Healthcare and pharmaceutical costs continue to rise year after year. While Maricopa County makes every effort to contain those costs and still offer rich benefits to its employees, increases to out-of-pocket costs were necessary in order to continue to offer the services employees value. Keep in mind that preventive medical services are still free. Also, monthly premiums only increased slightly and the employee share costs are still lower as compared locally to the City of Phoenix and the State of Arizona, and compare favorably nationwide. Incentives, such as biometric screening, health assessment, and non-tobacco user discounts are available to help offset the cost of your monthly premiums.

7. Do deductibles count towards my out-of-pocket maximum?

Except for the Choice Fund Health Savings Account medical plan, deductibles do not count towards your out-of-pocket maximum.

8. What is the impact of the new Health Insurance Reform Bill on my benefits?

While it seems that the new Health Insurance Reform Bill may have some impact on our benefits plans, the requirements of the bill are still being evaluated. Most likely, any changes impacting Maricopa County employees and their families will not be effective until the 2011/2012 Plan Year. This is primarily due to timing since

the bill's requirements become effective 6 months after the bill was signed (which was Tuesday, March 23) and must be implemented starting with an employer's next Plan Year effective date.

9. Why am I required to purchase my maintenance medication from Walgreens?

Maintenance medication must be purchased in 90-day quantities, after the first two 30-day fills. Walgreens offers Maricopa County the greatest discount, so in order to take advantage of that discount, 90-day quantities of maintenance medication must be purchased at Walgreens retail pharmacies or mail service.

10. I am leaning towards enrolling in the Choice Fund Medical Plan with the HSA, but would like more information about how it works. Where can I find that information?

There are several resources available to you on the Employee Benefits Web site regarding the Choice Fund Medical Plan and HSA. They are:

- The *What's New* 2010/2011 Open Enrollment Booklet
- The *Know Your Benefits* Booklet
- HSA FAQ's
- HSA Webinar hosted by a CIGNA representative
- Open Enrollment informational classes regarding the HSA, hosted by a CIGNA representative

You may also visit myCignaplans.com, which offers information and a comparison of all medical plans, including the HSA.

11. If I enroll in a Flexible Spending Account and choose to have a certain amount set aside every pay period, can I change that designated amount after Open Enrollment has closed (sometime during the benefit year)?

Flexible Spending Account (FSA) elections and contribution amounts cannot be changed after the close of Open Enrollment, unless you have a qualifying event (such as birth or marriage) during the plan year and that event is consistent with changing the amount of your FSA election. For example, if the qualifying event is a birth, then that event would be consistent with needing to increase (but not to decrease) the FSA amount.

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12. Is the full amount of my contributions to the Flexible Spending Account available immediately, or can I only submit claims for the amounts that have currently accrued in my account?

For the Health Care Flexible Spending Account, the full amount of your pledged annual contribution is generally available for use at the beginning of the plan year. There are some specific rules regarding payment for orthodontia expenses.

For the Dependent Care Flexible Spending Account, only contributions which have accrued in your account are available for use.

13. If I am currently waiving benefits because I am covered under my spouse's insurance, what do I need to do to continue receiving the waiver payment?

If you are waiving medical benefits through Maricopa County, each year you must provide verification of other coverage to the Employee Benefits Division in order to qualify for the medical waiver payment. (Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group medical insurance coverage for this purpose and therefore does not qualify you to receive the medical waiver payment.)

The documentation you submit must identify you as a covered member and include the name of the primary insured, the insurance company's name, address and phone number, group name and number, member identification number and coverage effective date. Please record the information above on the Verification of Insurance Form for Medical Waiver Payment, attach a copy of your insurance card, and fax it to the Employee Benefits Division at (602) 506-2354 by June 1.

14. If I am enrolled in the Consumer Choice Pharmacy plan and do not use the amount allotted to me in Level 1 and it rolls over to the next Plan Year, is there a way I can find out the amount of the rollover, along with my current balance?

You should contact the Employee Benefits Division at (602) 506-1010 for assistance, or send an e-mail to BenefitsService@mail.maricopa.com and a Benefits Analyst will research this for you.

15. If I am enrolled in the Consumer Choice Pharmacy plan and am in Level 2 and paying 100%, how is the amount calculated? The message states "average wholesale price minus discount or maximum allowable cost," but how do I find out what the components are?

This information is available to the Employee Benefits Division, but not until after a claim has been processed. Once the claim is processed, you may contact the Employee Benefits Division and a Benefits Analyst will review the pharmacy claim with you and advise you of the components used to calculate the cost.

You may also log on to www.mywhi.com and find the total discounted cost for a specific drug, but you will not be able to see each pricing component.

16. How do I find the locations for the CIGNA Care Today Clinics where I can receive services for the reduced primary care copayment?

Use the following link to find the most up-to-date list of the CIGNA CareToday locations: http://www.cigna.com/cmgaz/services/after-hours-caretoday.html.

17. How do I find the locations for the Take Care Clinics where I can receive services for the reduced primary care copayment?

Use the following link to find the most up-to-date list of the Take Care Clinic locations: http://www.takecarehealth.com/clinic-locations.aspx.

CASE MANAGEMENT

18. In regards to the Case Management Incentive, can you tell me what constitutes a "specific complex" medical condition?

Certain diagnoses trigger review for potential referrals to Case Management, as nationally recognized literature indicates that Case Management may make a positive difference in the outcome. Those diagnoses include:

- Prematurity;
- High-risk maternity/NICU admissions;
- Oncology;
- Traumatic brain injury;
- Multiple trauma injury;
- Respiratory failure;
- End-stage renal disease
- Transplants and organ failure;
- Multiple sclerosis and progressive neurological disorders;
- Rheumatoid arthritis;
- Hemophilia;
- HIV;
- Spinal cord trauma; and
- Burns.

A diagnosis does not automatically result in a referral to Case Management, since a diagnosis alone does not necessarily indicate that Case Management can add value for the individual. CIGNA uses multiple sources of information, such as claims data, lab data, prescription drug data, and CIGNA nurses' notes, to gain a more thorough understanding of the individual's particular situation.

In addition to specific diagnoses CIGNA reviews:

- Utilization patterns, including emergency room visits, visits to multiple doctors, inpatient admissions and/or risk for readmission and out-of-network utilization;
- High dollar claims;
- Potential gaps in care, including treatment that does not appear to meet nationally accepted standards of care for the illness or lack of compliance with the treatment plan;
- Behavior patterns, such as not filling prescriptions according to the prescribed schedule;
- Participation in and/or referrals from other CIGNA programs, such as enrollment in a CIGNA Well Aware for Better Health® disease management program;
- Recorded notes from CIGNA professionals;
- Information about the individual's particular situation, including length of the disease, intensity of the disease, and a support system of family, friends or community services; and
- Potential need for Case Management assistance with skilled nursing facility or hospice placement.

When all of these factors are taken into consideration, CIGNA identifies that in some instances a diagnosis that would suggest appropriateness for Case Management is not referred. As an example, CIGNA may find that an individual with an HIV diagnosis is compliant with prescribed medications and is not using emergency room or inpatient services, and does not need Case Management services. On the other hand, someone with a less severe diagnosis may demonstrate a number of behaviors that Case Management can address. For example, at the time of inpatient authorization, or through review of CIGNA predictive model reports, a member may be referred into Case Management who has a complicated migraine/pain management situation, or other individuals who appear at high risk despite a seemingly routine diagnosis. All individuals needing a transplant are referred to Case Management regardless of the diagnosis prompting the transplant.

It is the combination of in-context diagnosis review and the review of multiple other factors that help CIGNA to quickly and efficiently identify individuals for whom case management services are likely to provide value.

19. Does CIGNA determine the medical necessity for Case Management for an employee and does CIGNA make the determination for follow-up with a Case Manager?

A Senior Medical Executive/Medical Director reviews these matters on a case-by-case basis, and makes the determination accordingly.

20. Is the need for a Case Manager being determined through participation in the Biometric Screening and Health Assessment?

No. The results of biometric screening and health assessment are confidential and are not used to determine the need for Case Management.

21. Is the employee's own health care provider involved in the decision-making process and treatment plan after CIGNA makes their initial Case Management assessment?

Yes, an employee's health care provider is engaged in the process.

22. Are there certain health risks that have been already pre-determined to require a Case Manager?

Complex/Catastrophic conditions are managed by Case Management, i.e. High Risk Maternity, NICU (Neonatal Intensive Care Unit) Infants with health concerns, Cancer, and Head/Spinal cord injuries.

23. If CIGNA is managing the employee/patient's treatment plan and the employee receives a second opinion from his/her physician which is not in agreement with the Case Manager, what course of action would be followed?

There is an appeal process and a peer review can be done between the attending physician and CIGNA.

Disclaimer: *These FAQs are intended to provide brief and general information about Maricopa County benefits. Specific eligibility and coverage requirements are not covered in these FAQs. For more in-depth information, please refer to the 'What's New Booklet', the 'Know Your Benefits Booklet', or the Official Plan documents. If there is a discrepancy between the information provided in these FAQs and the Official Plan documents, the Official Plan documents govern.*

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